Family Planning in

KEITH P. RUSSELL, M.D., *Los Angeles*, AND GITTA MEIER, M.A., *Berkeley*

■ *Although the availability of oral contraceptives and the development of improved intrauterine contraceptive devices have greatly increased the general utilization of family planning services, there are still great segments of our population which are not yet reached, especially in the economically deprived areas. Since over 98 percent of all obstetrical deliveries now occur in hospitals, it seems logical that it is on hospital maternity services that these deficiencies might often be best overcome. Although this is primarily a medical problem, the use of paramedical personnel can greatly augment the physician's practice in these areas. Family planning services should be an integral part of comprehensive maternity care, not alone in the physician's office but also in the hospital setting.*

The Hospital Setting

THE POLICY STATEMENT on family planning adopted by the California Hospital Association in 1968 gives formal recognition to the concern of hospital administrative and medical staffs for the provision of family planning services. The statement affirmed that "professional assistance with child spacing and family limitation information and service should be an integral part of a comprehensive maternal care program," and that "hospital boards and the medical staffs should seek opportunities to help develop needed family planning services." The California Hospital Association has thus become the first state-wide hospital association to join the American Medical Association, American College of Obstetricians and Gynecologists, American Public Health Association, American Nurses' Association, California Medical Association, California Conference of Local Health Officers, and many other organizations in strongly endorsing the inclusion of family planning assistance among the professional responsibilities of their members.

Although the advent of oral contraceptives and intrauterine devices has greatly increased the anticonception protection obtained from professional sources among all segments of the population, surveys have pointed up inadequacies in such protection among the poor and the poorly educated. On the basis of available information it has been estimated that in the United States between 4,600,000 and 5,300,000 women in the very low income group required reliable assistance with child spacing; only about 700,000 of such women were known to have been reached by existing family planning programs under hospital, public health, Planned Parenthood, and Office of Economic Opportunity (OEO) sponsorship during 1967.[2] Corresponding local estimates indicate that in California considerably less than one-third and possibly not more than one-fourth of women in the very low income group are receiving family planning assistance from professional sources.[5] Most of these women continue to resort to generally less reliable and less satisfactory non-prescription methods of fertility control. Unplanned, unwanted and problem-creating pregnancies still are a common occurrence for them, due both to failure of these methods, and to failure to use the methods correctly.

Family Planning Assistance Provided by Hospitals

Postpartum prescription of contraception has become a well established medical practice. It is of greatest value to women who did not have professional asistance with contraception earlier. The most strategic opportunity for orientation in family planning practices by these patients is offered at the time of prenatal and post-delivery contacts, followed by prescription before discharge from hospital or at the time of the postpartum check-up. For this reason, the obstetric and gynecologic services of hospitals in California must assume a major role in the delivery of family planning assistance, adding to and complementing the services already available through private physicians, health departments, Planned Parenthood, and OEO sponsored clinics.

Chairman, Committee on Maternal and Child Care, California Medical Association (Russell); Consultant, California Interagency Council on Family Planning (Meier).

Submitted 1 July 1968.

Reprint requests to: 266 South Harvard Boulevard, Los Angeles 90004 (Dr. Russell).

Services to Non-Private Maternity Patients

With some significant exceptions,* in California as elsewhere, systematic hospital-based family planning assistance has been limited (though not assured) to patients who are receiving their obstetric and other medical care as staff or ward cases rather than as private patients. For the most part, this includes those in two overlapping categories: county hospital patients and staff patients in teaching hospitals that have residencies in obstetrics and gynecology. The institutions in the latter group vary with respect to other important characteristics: for example, some are affiliated with or operated by medical schools, others are conducting independent residency programs; some are church-owned and controlled, some are county or city hospitals, others are non-profit or community hospitals. Most, but by no means all, report more than a thousand deliveries annually. For some, the bulk of deliveries involves staff patients; for others such deliveries make up only a minor fraction. Presumably, admission to obstetric care as a staff patient is based on income limitation in almost all of these hospitals; and from this it can be assumed that these patients fall into the medically indigent or very low income group.

What family planning services are these county hospitals and teaching hospitals providing at present? Preliminary estimates based on 1966 data of varying accuracy indicate that in the 29 California county hospitals which reported any sort of family planning services, over 44,000 deliveries occurred. Fewer than 20,000 of the patients involved were reported as having received even initial contraceptive assistance through the hospital. Over 10,000 additional births occured in the remaining county hospitals which did not report any family planning services for 1966. Among the hospitals reporting services, the proportion of maternity patients served ranges from about 60 percent of the total in one facility to 0.6 percent in another. In the majority of hospitals, less than one-third of new mothers appear to have received contraceptive assistance. Family planning services provided by health departments, farm workers' health centers, Planned Parenthood and OEO family planning clinics make up for some of these deficiencies, but reports from these agencies emphasize their inability to serve all these women effectively.

The American College of Obstetricians and Gynecologists, together with the Center for Population Planning of the University of Michigan, is surveying the family planning services provided by teaching hospitals throughout the United States. Preliminary analyses for California and other states point toward wide differences in the percentage of non-private maternity patients accepting contraceptive services among hospitals serving seemingly similar patient groups. Also, a significant proportion of these patients do not return for postpartum examination.[3] Some of those who do not return may be receiving six-week checkups or family planning assistance from their own physicians or from health department and planned parenthood clinics. However, in most communities even an optimistic estimate of family planning assistance received from alternate sources leaves an important segment of recent maternity patients in these hospitals unprotected against another pregnancy in the 12-month period following birth.[5] Yet, this is the period during which another pregnancy often is considered by physicians as undesirable in consideration of the mother's health.[7]

Experience throughout the United States has shown that the introduction of contraceptive services by hospitals where none was offered before will improve previously unsatisfactory return rates for postpartum checkups, and that a majority of women who do return will accept contraception at that time. Among the features directly related to family planning services that appear to contribute to satisfactory return and acceptance rates are:

- Emphasis by the OB/GYN department that contraceptive assistance is an essential and integral part of good OB/GYN and general medical practice.
- Utilization of prenatal clinics, and patient teaching sessions pre- and postnatally for discussion of family planning; discussion of the subject with each individual patient before discharge; written information for patients on available services and methods.
- Orientation of nursing and social work personnel, medical students and other house staff, and appropriate clerks and receptionists.
- Removal of restrictions with respect to marital status, age and residence of patients.
- Provision of family planning information and services to patients whose pregnancies did not terminate in live births.
- Scheduling of family planning services or clinics so as to facilitate attendance—for example,

*Military hospitals now are including family planning assistance in their obstetric and gynecologic services for military dependents.

as part of the postpartum examination, or directly following postpartum clinic appointment; utilization of unavoidable waiting periods for patient teaching, movies, etc.; evening clinics; simplification of prescription filling procedures.

- Arrangements for return visits at the hospital or in clinics closer to patient's home for family planning assistance at free or part pay rates.
- Referral to public health nurses, visiting nurses or neighborhood workers for follow-up contacts; employment of a liaison nurse in the hospital for patient education and arranging referrals.
- Strong administrative backing and cooperation in the introduction and operation of family planning services, so as to make possible the organizational and budgetary adjustments required for an effective program.

The data collected by the California State Department of Public Health and the American College of Obstetricians and Gynecologists' survey of teaching hospitals provide only incidental information on other factors that are known to influence postpartum return rates and thus contraceptive acceptance rates: overcrowded, impersonal clinics, long waiting periods, cost and inconvenience of transportation to clinics, language barriers, frequent changes of staff, long-standing antagonism toward certain institutions on the part of that population depending upon them for service, and other similar factors. Those hospitals with very high postpartum return and acceptance rates among their maternity patients have been able to minimize or eliminate these impediments.

Services to Private Patients

Even before the introduction of the Medi-Cal program, a very substantial group of patients in the very low income group and patients who might be considered high pregnancy risks due to their age, parity or obstetrical history were not delivered in county hospitals or as staff patients in teaching hospitals, but as private patients in non-profit or proprietary hospitals. A preliminary analysis based on 1965 birth certificates indicates that about 45,000 women who were under 18 years of age, or had five or more children, or had late or no prenatal care (or a combination of these three) gave birth in such hospitals. A majority of these also are known to fall into the very low income group. With the implementation of Medi-Cal, much larger numbers of women in these high risk categories can be expected to register as private maternity patients.

Notwithstanding the growing professional concern with family planning, individual physicians still vary considerably in their emphasis on family planning, especially in the absence of patient request or obvious medical contraindications to pregnancy. Some are understandably reluctant to initiate contraceptive counseling with unmarried patients; others will not discuss family planning on account of religious convictions.[1] Moreover, not all private maternity patients return for postpartum checkup—when physicians traditionally may discuss family planning. It is also true that for a busy physician a really thorough discussion of family planning—preference as to number of children, choice of methods, problems of usage, and other aspects—can be very time-consuming, especially with a poorly educated patient. This combination of practical obstacles to a comprehensive orientation and provision of family planning services by physicians for their private patients points to the great potential contribution which the hospital staff, in close cooperation with the attending physicians, can make in this field.

Assistance for Other Patient Categories

The gynecologic services in most hospitals provide an important source of contraceptive assistance for women who have not recently given birth. In addition, many chiefs of obstetrics-gynecology are bringing new developments in fertility control and family planning services in their hospitals, to the attention of medical personnel in other departments. Operation of an active and visible family planning clinic in itself tends to generate greater interest in counseling and referrals.[4]

There is lack of information about the extent to which hospital discussion of contraception has become standard procedure with non-maternity patients in the childbearing age group, in the absence of serious medical contraindications to pregnancy or direct patient request. In some instances, no doubt counseling and prescription occur within the Internal Medicine department or some other specialty service. Discussion and referral appear also to be occurring with increasing frequency on the psychiatric services of general hospitals. Similarly, many pediatric departments in California and throughout the country have come to recognize their responsibility for the "primary prevention of pregnancy" among adolescents, as well as for "secondary prevention" among young mothers. On the other hand, patients and their spouses on

leave or about to be discharged from institutions for the mentally ill or from tuberculosis sanitaria constitute important and definitive groups whose special needs for protection against unplanned pregnancies still are often neglected.

The Hospital as Source of Family Planning Information

With respect to family planning, as with many other health concerns, an important responsibility of hospitals is to provide up-to-date information and advice on various health services existing in the community. Thus, receptionists, switchboard operators and other staff personnel in direct contact with patients and the public should be able to offer appropriate and accurate information about sources of family planning assistance in the community. Requests for such information probably are most frequent in hospitals where family planning clinics with restrictions on eligibility for service are located. "Non-eligible" patients have been known to be turned away without referral to available alternative resources by hospital staff members who were unaware of the existence of such resources.

Most of the following suggestions include practices that already have been adopted in some hospitals, or by individual staff members:

- Inclusion, among the items of health information given to new mothers, of some of the many excellent brochures on family planning available through Planned Parenthood and various drug companies.
- Use of booklets on baby care which discuss resumption of intercourse and contraception. Many hospitals have prepared such literature for both private and non-private patients.
- Emphasis on the responsibility of the nurses on the maternity floor to ascertain whether the new mother wishes to discuss contraceptive methods and related questions with her physician before leaving the hospital, much in the same way as the nurses are expected to encourage patients to discuss questions related to diet or various aspects of baby care. In turn, the nurses would have the additional responsibility of calling to the physician's attention any fears, doubts or questions in this area the patient might have.
- Use of up-to-date films or tapes on family planning in parents' classes and in formal or informal sessions on the wards.
- With consent of the patient's physician, referral to public health nurses or visiting nurses of patients for whom medical or other contraindications to rapid order pregnancies exist. Before Medi-Cal, many such patients would have been assured of routine home calls by public health nurses who would have discussed family planning with them. Now this additional reminder and orientation will not be available to them unless their physicians or someone assigned that duty in the hospital make special arrangements for such follow-up contacts.

All of the foregoing suggestions require a measure of staff education and orientation so as to clarify the respective responsibilities of all concerned within the hospital. In most hospital settings, nurses will be the staff members most frequently involved in this patient orientation. It is of interest here that the California State Health Department's nursing consultants, on the basis of their contacts with nurses staffing private units, report a growing concern on the part of the latter nurses for more systematic involvement in these activities. At the moment, many nurses are held back by the lack of clear instructions from hospital administrations and medical staffs.

In some hospitals, other heavy demands on nursing time may favor the utilization of public health liaison nurses or appropriately supervised and trained volunteers or sub-professional staff, to discuss family planning with maternity patients.[6] In hospitals with social service departments, social workers have already assumed responsibilities for systematic counseling and referrals, or can be encouraged to do so. In this connection, suggestions for family planning education and services in hospitals and source material for staff orientation are currently being prepared by the State Health Department's Bureau of Maternal and Child Health.

Conclusion

Logistic reasons alone argue for a strong emphasis on family planning in the hospital setting, most particularly in hospitals with obstetric services. Logistic reasons of a different sort have led to the expansion of neighborhood-centered family planning services, together with increased emphasis on contraceptive assistance provided by physicians in private practice. It is important that these be complementary developments, rather than alternatives.

As with many other hospital services, the lack of funds, space or qualified staff so far has prevented or hampered the development of optimal family planning assistance in most hospitals. The recent allocation of federal funds for family planning projects under both public and private auspices provides a new incentive for hospitals to introduce these services and to expand and improve existing services. It is anticipated that many California hospitals will join health departments and other community agencies in developing programs which will qualify them for Children's Bureau or Office of Economic Opportunity grants for this purpose, as is already happening in Los Angeles County through the Los Angeles Regional Family Planning Council, Inc.

The responsibility of hospitals and of hospital staffs needs to go beyond the development of these specialized programs. It is confidently expected that the recognition provided by the California Hospital Association's recent policy statement will serve, as stressed in its introductory paragraph, "to facilitate the efforts made by physicians, nurses and others directly involved with providing family planning assistance and increase the availability of information and services to the many individuals not so far being reached."

REFERENCES

1. The American College of Obstetricians and Gynecologists, College Committee on Public Education—Report on the questionnaire, Survey of Experience with Oral Contraceptive Pills, Chicago, Ill., Oct. 1967.

2. Harkavy, O., Jaffe, F. S., and Wishik, S. M.: Implementing DHEW policy on family planning and population—A consultants' report to the U.S. Department of Health, Education, and Welfare, Sept. 1967, 44 pp.

3. Hibbard, L. T.: Postpartum sterilization, Calif. Med., 107:504-507, Dec. 1967.

4. Perkin, G. W.: A family planning unit for your hospital, Hosp. Pract., 2:64-72, May 1967.

5. State of California: Population study commission—Report to the Governor, State of California Department of Public Health, Berkeley, 1967.

6. Swartz, D. P., Bullard, T. H., and Felton, H. T.: The introduction of contraception in an urban public hospital, Amer. J. Obstet. Gynec., 97:189-196, 15 Jan. 1967.

7. Taylor, H. C., Jr.: A family planning program related to a maternity service, Amer. J. Obstet. Gynec., 95:726-731, 1 July 1966.

TROUBLE-MAKING ELECTRONS

"If the electrical equipment we use today in the operating room is not properly grounded, it is very easy with infinitesimal currents to produce ventricular fibrillation. It is particularly easy if the equipment is not properly grounded to produce burns, and these burns will go through your EKG leads if that serves as the ground for the cautery. If the cautery's ground is defective and you're monitoring with an EKG, then the contact point of the EKG becomes the ground for the cautery, and you get a burn because the current density is strong enough. It's that simple. But that's just a burn. The others will produce ventricular fibrillation. . . . This is something you have to be aware of."

—VALENTINO D. B. MAZZIA, M.D., New York City
Extracted from *Audio-Digest Otorhinolaryngology,* Vol. 1, No. 5, in the Audio-Digest Foundation's subscription series of tape-recorded programs.